REFERENCE F: HEALTH CARE CLAIM ADJUSTMENT REASON CODES

(Last Updated 9/2003)

Please note that all information listed below was accurate per the Centers for Medicare & Medicaid Services (CMS) website at the time of printing; however, this information is subject to change.

Health Care Claim Adjustment Reason Codes are used to explain any adjustment in payment. This code list is updated quarterly as necessary, and can be downloaded at http://www.wpc-edi.com/Codes/Codes.asp on the Web.

Code	Description	Notes
1	Deductible Amount.	
2	Coinsurance Amount.	
3	Co-payment Amount.	
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	
5	The procedure code/bill type is inconsistent with the Place of Service (POS).	
6	The procedure/revenue code is inconsistent with the patient's age.	Changed as of 6/02
7	The procedure/revenue code is inconsistent with the patient's gender.	Changed as of 6/02
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	Changed as of 6/02
9	The diagnosis is inconsistent with the patient's age.	
10	The diagnosis is inconsistent with the patient's gender.	Changed as of 2/00
11	The diagnosis is inconsistent with the procedure.	
12	The diagnosis is inconsistent with the provider type.	
13	The date of death precedes the date of service.	
14	The date of birth follows the date of service.	
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	Changed as of 2/01
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using Remittance Advice remarks codes whenever appropriate.	Changed as of 2/02
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the Remittance Advice remarks codes whenever appropriate.	Changed as of 2/02

Code	Description	Notes
18	Duplicate claim/service.	
19	Claim denied because this is a work-related injury/illness and thus the liability of the Workers' Compensation carrier.	
20	Claim denied because this injury/illness is covered by the liability carrier.	
21	Claim denied because this injury/illness is the liability of the no-fault carrier.	
22	Payment adjusted because this care may be covered by another payer per Coordination of Benefits (COB).	Changed as of 2/01
23	Payment adjusted because charges have been paid by another payer.	Changed as of 2/01
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	Changed as of 6/00
25	Payment denied. Your stop loss deductible has not been met.	
26	Expenses incurred prior to coverage.	
27	Expenses incurred after coverage terminated.	
28	Coverage not in effect at the time the service was provided.	Inactive for 004010, since 6/98. Redundant to Codes 26 and 27.
29	The time limit for filing has expired.	
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	Changed as of 2/01
31	Claim denied as patient cannot be identified as our insured.	
32	Our records indicate that this dependent is not an eligible dependent as defined.	
33	Claim denied. Insured has no dependent coverage.	
34	Claim denied. Insured has no coverage for newborns.	
35	Lifetime benefit maximum has been reached.	Changed as of 10/02
36	Balance does not exceed co-payment amount.	Inactive for 003040
37	Balance does not exceed deductible.	Inactive for 003040
38	Services not provided or authorized by designated (network/primary care) providers.	Changed as of 6/03
39	Services denied at the time authorization/pre-certification was requested.	
40	Charges do not meet qualifications for emergent/urgent care.	
41	Discount agreed to in Preferred Provider contract.	Inactive for 003040
42	Charges exceed our fee schedule or maximum allowable amount.	
43	Gramm-Rudman reduction.	
44	Prompt-pay discount.	
45	Charges exceed your contracted/ legislated fee arrangement.	
46	This (these) service(s) is (are) not covered.	Inactive for 004010, since 6/00. Use Code 96.

Code	Description	Notes
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	Changed as of 6/00
48	This (these) procedure(s) is (are) not covered.	Inactive for 004010, since 6/00. Use Code 96.
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.	
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	
51	These are non-covered services because this is a pre-existing condition.	
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service.	Changed as of 10/98
53	Services by an immediate relative or a member of the same household are not covered.	
54	Multiple physicians/assistants are not covered in this case.	
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.	
56	Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by the payer.	
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	Inactive for 004050. Split into Codes 150, 151, 152, 153 and 154.
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	Changed as of 2/01
59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.	Changed as of 6/00
60	Charges for outpatient services with this proximity to inpatient services are not covered.	
61	Charges adjusted as penalty for failure to obtain second surgical opinion.	Changed as of 6/00
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	Changed as of 2/01
63	Correction to a prior claim.	Inactive for 003040
64	Denial reversed per Medical Review.	Inactive for 003040
65	Procedure Code was incorrect. This payment reflects the correct code.	Inactive for 003040
66	Blood Deductible.	
67	Lifetime reserve days. (Handled in QTY, QTY01=LA)	Inactive for 003040
68	DRG weight. (Handled in CLP12)	Inactive for 003040
69	Day outlier amount.	
70	Cost outlier - Adjustment to compensate for additional costs.	Changed as of 6/01

Code	Description	Notes
71	Primary Payer amount.	Deleted as of 6/00. Use Code 23.
72	Coinsurance day. (Handled in QTY, QTY01=CD)	Inactive for 003040
73	Administrative days.	Inactive for 003050
74	Indirect Medical Education Adjustment.	
75	Direct Medical Education Adjustment.	
76	Disproportionate Share Adjustment.	
77	Covered days. (Handled in QTY, QTY01=CA)	Inactive for 003040
78	Non-Covered days/Room charge adjustment.	
79	Cost Report days. (Handled in MIA15)	Inactive for 003050
80	Outlier days. (Handled in QTY, QTY01=OU)	Inactive for 003050
81	Discharges.	Inactive for 003040
82	PIP days.	Inactive for 003040
83	Total visits.	Inactive for 003040
84	Capital Adjustment (Handled in MIA).	Inactive for 003050
85	Interest amount.	
86	Statutory Adjustment.	Inactive for 004010, since 6/98. Duplicative of Code 45.
87	Transfer amount.	
88	Adjustment amount represents collection against receivable created in prior overpayment.	Inactive for 004050
89	Professional fees removed from charges.	
90	Ingredient cost adjustment.	
91	Dispensing fee adjustment.	
92	Claim Paid in full.	Inactive for 003040
93	No Claim level Adjustments.	Inactive for 004010, since 2/99. In 004010, CAS at the claim level is optional.
94	Processed in excess of charges.	
95	Benefits adjusted. Plan procedures not followed.	Changed as of 6/00
96	Non-covered charge(s).	
97	Payment is included in the allowance for another service/procedure.	Changed as of 2/99
98	The hospital must file the Medicare claim for this inpatient non-physician service.	Inactive for 003040
99	Medicare Secondary Payer Adjustment Amount.	Inactive for 003040
100	Payment made to patient/insured/responsible party.	
101	Predetermination: anticipated payment upon completion of services or claim adjudication.	Changed as of 2/99

Code	Description	Notes
102	Major Medical Adjustment.	
103	Provider promotional discount (e.g., senior citizen discount).	Changed as of 6/01
104	Managed care withholding.	
105	Tax withholding.	
106	Patient payment option/election not in effect.	
107	Claim/service denied because the related or qualifying claim/service was not paid or identified on this claim.	Changed as of 6/03
108	Payment adjusted because rent/purchase guidelines were not met.	Changed as of 6/02
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	
110	Billing date predates service date.	
111	Not covered unless the provider accepts assignment.	
112	Payment adjusted as not furnished directly to the patient and/or not documented.	Changed as of 2/01
113	Payment denied because service/procedure was provided outside the United States or as a result of war.	Changed as of 2/01
114	Procedure/product not approved by the Food and Drug Administration.	
115	Payment adjusted as procedure postponed or canceled.	Changed as of 2/01
116	Payment denied. The advance indemnification notice signed by the patient did not comply with requirements.	Changed as of 2/01
117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.	Changed as of 2/01
118	Charges reduced for ESRD network support.	
119	Benefit maximum for this time period has been reached.	
120	Patient is covered by a managed care plan.	Inactive for 004030, since 6/99. Use Code 24.
121	Indemnification adjustment.	
122	Psychiatric reduction.	
123	Payer refund due to overpayment.	Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals.
124	Payer refund amount - not our patient.	Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the Remittance Advice remarks codes whenever appropriate.	Changed as of 2/02

Code	Description	Notes
126	Deductible - Major Medical.	New as of 2/97
127	Coinsurance - Major Medical.	New as of 2/97
128	Newborn's services are covered in the mother's Allowance.	New as of 2/97
129	Payment denied - Prior processing information appears incorrect.	Changed as of 2/01
130	Claim submission fee.	Changed as of 6/01
131	Claim specific negotiated discount.	New as of 2/97
132	Prearranged demonstration project adjustment.	New as of 2/97
133	The disposition of this claim/service is pending further review.	Changed as of 10/99
134	Technical fees removed from charges.	New as of 10/98
135	Claim denied. Interim bills cannot be processed.	New as of 10/98
136	Claim Adjusted. Plan procedures of a prior payer were not followed.	Changed as of 6/00
137	Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.	New as of 2/99
138	Claim/service denied. Appeal procedures not followed or time limits not met.	New as of 6/99
139	Contracted funding agreement - Subscriber is employed by the provider of services.	New as of 6/99
140	Patient/Insured health identification number and name do not match.	New as of 6/99
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	Changed as of 6/00
142	Claim adjusted by the monthly Medicaid patient liability amount.	New as of 6/00
143	Portion of payment deferred.	New as of 2/01
144	Incentive adjustment (e.g., preferred product/service).	New as of 6/01
145	Premium payment withholding.	New as of 6/02
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	New as of 6/02
147	Provider contracted/negotiated rate expired or not on file.	New as of 6/02
148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.	New as of 6/02
149	Lifetime benefit maximum has been reached for this service/benefit category.	New as of 10/02
150	Payment adjusted because the payer deems the information submitted does not support this level of service.	New as of 10/02
151	Payment adjusted because the payer deems the information submitted does not support this many services.	New as of 10/02
152	Payment adjusted because the payer deems the information submitted does not support this length of service.	New as of 10/02
153	Payment adjusted because the payer deems the information submitted does not support this dosage.	New as of 10/02

Code	Description	Notes
154	Payment adjusted because the payer deems the information submitted does not support this day's supply.	New as of 10/02
155	This claim is denied because the patient refused the service/procedure.	New as of 6/03
156	Flexible spending account payments.	New as of 6/03
157	Payment denied/reduced because service/procedure was provided as an act of war.	New as of 9/03
158	Payment denied/reduced because service/procedure was provided outside of the U.S.	New as of 9/03
159	Payment denied/reduced because service/procedure was provided as a result of tourism.	New as of 9/03
160	Payment denied/reduced because service/procedure was provided as a result of an activity that is a benefit exclusion.	New as of 9/03
A0	Patient refund amount.	
A1	Claim denied charges.	
A2	Contractual adjustment.	
A3	Medicare Secondary Payer liability met.	Inactive for 004010, since 6/98.
A4	Medicare Claim PPS Capital Day Outlier Amount.	
A5	Medicare Claim PPS Capital Cost Outlier Amount.	
A6	Prior hospitalization or 30-day transfer requirement not met.	
A7	Presumptive Payment Adjustment.	
A8	Claim denied; ungroupable DRG.	
B1	Non-covered visits.	
B2	Covered visits.	Inactive for 003040
B3	Covered charges.	Inactive for 003040
B4	Late filing penalty.	
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	Changed as of 2/01
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.	Changed as of 2/01
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	Changed as of 10/98
B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.	
B9	Services not covered because the patient is enrolled in a Hospice.	
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	

Code	Description	Notes
B12	Services not documented in patients' medical records.	
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	
B14	Payment denied because only one visit or consultation per physician per day is covered.	Changed as of 2/01
B15	Payment adjusted because this procedure/service is not paid separately.	Changed as of 2/01
B16	Payment adjusted because 'New Patient' qualifications were not met.	Changed as of 2/01
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.	Changed as of 2/01
B18	Payment denied because this procedure Code/modifier was invalid on the date of service or claim submission.	Changed as of 2/01
B19	Claim/service adjusted because of the finding of a Review Organization.	Inactive for 003070
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.	Changed as of 2/01
B21	The charges were reduced because the service/care was partially furnished by another physician.	Inactive for 003040
B22	This payment is adjusted based on the diagnosis.	Changed as of 2/01
B23	Payment denied because this provider has failed an aspect of a proficiency testing program.	Changed as of 2/01
D1	Claim/service denied. Level of subluxation is missing or inadequate.	Inactive for 004010, since 2/99. Use Code 16 and Remark Codes if necessary.
D2	Claim lacks the name, strength, or dosage of the drug furnished.	Inactive for 004010, since 2/99. Use Code 16 and Remark Codes if necessary.
D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.	Inactive for 004010, since 2/99. Use Code 16 and Remark Codes if necessary.
D4	Claim/service does not indicate the period of time for which this will be needed.	Inactive for 004010, since 2/99. Use Code 16 and Remark Codes if necessary.
D5	Claim/service denied. Claim lacks individual Laboratory Codes included in the test.	Inactive for 004010, since 2/99. Use Code 16 and Remark Codes if necessary.

Code	Description	Notes
D6	Claim/service denied. Claim did not include patient's medical record for the service.	Inactive for 004010, since 2/99. Use Code 16 and Remark Codes if necessary.
D7	Claim/service denied. Claim lacks date of patient's most recent physician visit.	Inactive for 004010, since 2/99. Use Code 16 and Remark Codes if necessary.
D8	Claim/service denied. Claim lacks indicator that 'x-ray is available for review'.	Inactive for 004010, since 2/99. Use Code 16 and Remark Codes if necessary.
D9	Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.	Inactive for 004010, since 2/99. Use Code 16 and Remark Codes if necessary.
D10	Claim/service denied. Completed physician financial relationship form not on file.	Inactive for 003070, since 8/97. Use Code 17.
D11	Claim lacks completed pacemaker registration form.	Inactive for 003070, since 8/97. Use Code 17.
D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.	Inactive for 003070, since 8/97. Use Code 17.
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.	Inactive for 003070, since 8/97. Use Code 17.
D14	Claim lacks indication that plan of treatment is on file.	Inactive for 003070, since 8/97. Use Code 17.
D15	Claim lacks indication that service was supervised or evaluated by a physician.	Inactive for 003070, since 8/97. Use Code 17.
W1	Workers' Compensation State Fee Schedule Adjustment.	New as of 2/00